DEPARTMENT OF HEALTH AND HUMAN SERVICES							
CENTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(2				

AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMI	(X3) DATE SURVEY COMPLETED 09/02/2011	
NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN46268				
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)	
PREFIX	1	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE APPROPRIATE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0000	State Licensure included the inv IN00094720 and Complaint IN00 due to lack of ex Complaint IN00 due to lack of ex Survey dates: A September 1, an Facility Number Provider Number AIM Number: Survey Team: Janet Stanton, R Michelle Hostet Rita Mullen, R.M.	2094720: Unsubstantiated vidence. 2095318: Unsubstantiated vidence. 209318: Unsubstantiated vidence. 209318: Unsubstantiated vidence. 209318: Unsubstantiated vidence. 209318: Unsubstantiated vidence. 2095318: U	F0000	The following is the F Correction for Robin Healthcare Center re Statement of Deficier 9/2/11. This Plan of not to be construed a admission of or agreethe finings and concl Statement of Deficier related sanction or finis submitted as confinour ongoing efforts to statutory and regulat requirements. In this we have outlined spein response to identified We have not provide response to each allefinding, nor have we mitigating factors. We committed to the deliquality health care sewill continue to make and improvement to objective.	Run egarding the ncies dated Correction is as an ement with lusions in the ncies, or any ne. Rather, it rmation of comply with cory s document, ecific actions fied issues. ad a detailed egation or identified We remain ivery of ervices and e changes		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

B3HQ11

Facility ID:

001156

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505		A. BUILDING	00	COMPLETED 09/02/2011	
		100000	B. WING	ADDRESS, CITY, STATE, ZIP CODE	03/02/2011
NAME OF I	PROVIDER OR SUPPLIER			OBIN RUN W	
	RUN HEALTH CENT			IAPOLIS, IN46268	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
1710	Other10	ESC IDENTI TING IN ORGANITORY	1710		DATE
	Total70				
	10111 70				
	Sample: 15				
	These deficiencie	es reflect State findings			
		ice with 410 IAC 16.2.			
	Quality review co	ompleted on September			
	9, 2011 by Bev F	-			
F0252 SS=B	comfortable and hallowing the reside personal belonging Based on observation facility failed to environment in the on the Health Califting equipment was stored in 1 oareas on 1 of 2 restoring of equipment shower room had	st provide a safe, clean, d homelike environment, sident to use his or her gings to the extent possible. Ervation and interview, the to maintain a homelike in the common shower room. Care unit by storing resident ent in the area. Equipment all of 2 common shower. It is resident care units. The impent in the common in the potential to affect 49 ling on the Health Care unit,		The following is the Plan of Correction for Robin Run Healthcare Center regarding Statement of Deficiencies da 9/2/11. This Plan of Correcti not to be construed as an admission of or agreement with finings and conclusions i Statement of Deficiencies, or related sanction or fine. Rat is submitted as confirmation our ongoing efforts to comply statutory and regulatory	ated ion is with in the ir any ther, it of y with
	Findings include			requirements. In this docum we have outlined specific ac in response to identified issu	itions ues.
	During the environmental tour with the Director of Housekeeping, Maintenance Engineer #1 and Maintenance Engineer			We have not provided a deta response to each allegation finding, nor have we identifie mitigating factors. We rema committed to the delivery of quality health care services a	or ed in

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/02/2011	
	PROVIDER OR SUPPLIER		6370 R	ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W JAPOLIS, IN46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	shower room on observed to have area for toileting used to transfer remiddle of the area sling lifts and 1 lestored in the mid in use. During an interve Housekeeping, of was indicated the	19:30 A.M., the common the Health Care Unit was a two shower stalls and an residents. Equipment residents was sitting in the rea. There were 3 hydraulic mydraulic stand lift being ddle of the room while not liew with the Director of an 8/30/11 at 9:35 A.M., it requipment should not ddle of the shower room		will continue to make change and improvement to satisfy to objective. I. All residents have potential to be affected by the deficient practice. The deficient practice was corrected immediately on 9/1/11 by relocating the lifting equipmed one speicific area. II. All resident practice at the facility have the potential to be affected by the deficient practice. The facility conduct a daily round to ensight that the lifting equipment is so in the appropriate area. III. In order to prevent the deficient practice from recurring, the facility educate all nursing staff members on the proper storal location of the lifting equipments of the objective to provide a safe, clean, comformand homelike environment. In the facility will monitor the corrective action by perform nursing rounds daily, for one month and weekly for one month and month and w	that we the e e ient ent to dents he e ty will ure stored tracility age ent bers rtable v. ing e ionth. terly e I be

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00 COM	(X3) DATE SURVEY	
A. BUILDING	COMPLETED	
155505 B. WING 09/02/	/2011	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
6370 ROBIN RUN W		
ROBIN RUN HEALTH CENTER INDIANAPOLIS, IN46268		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	COMPLETION	
THE REGULATOR DRESCRIPTION THOUSAND THE STATE OF THE STAT	DATE	
F0309 Each resident must receive and the facility SS=D must provide the necessary care and services		
to attain or maintain the highest practicable		
physical, mental, and psychosocial well-being,		
in accordance with the comprehensive		
assessment and plan of care. Based on record review and interview, the F0309 The following is the Plan of	10/02/2011	
Opening the Debit Day	10/02/2011	
Healthcare Center regarding the		
bruit/thrill of an A.V. [arterio-venous] Statement of Deficiencies dated		
shunt hemodialysis access site for 1 of 1 9/2/11. This Plan of Correction is		
dialysis residents reviewed; and failed to not to be construed as an admission of or agreement with		
assess a resident for symptoms of a the finings and conclusions in the		
urinary tract infection (U.1.1.) during Statement of Deficiencies, or any		
antibiotic treatment for 1 of 3 residents related sanction or fine. Rather, it		
reviewed with U.T.I.'s; in a sample of 15.		
[Residents #9 and #23] our ongoing efforts to comply with statutory and regulatory		
requirements. In this document,		
Findings include: we have outlined specific actions		
in response to identified issues.		
1. The clinical record for Resident #9 was We have not provided a detailed		
reviewed on 9/1/11 at 9:30 A.M. response to each allegation or finding, nor have we identified		
Diagnoses included, but were not limited mitigating factors. We remain		
to, end stage renal disease with committed to the delivery of		
hemodialysis, diabetes mellitus, high quality health care services and		
blood pressure, dementia and history of will continue to make changes and improvement to satisfy that		
urinary tract infection. A progress note objective I. All residents have the		
from the dialysis center, dated 7/14/11, potential to be affected by the		
indicated the resident had an deficient practice. The deficient		
arterio-venous fistula dialysis access shunt practice was corrected on 9/1/11 to include assess for bruit and		
in the left upper arm. thrill of access site daily.II. All		
charts have been reviewed for		
The D.O.N. (Director of Nursing) other residents with dialysis sites		
indicated the assessment of a fixtula		
bruit/thrill [the sound heard by antibiotics. All residents with dialysis access sites will have		
auscultation/vibration felt on palpation] his/her access site assessed for		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA (X2)		(X2) MULTIPLE CONSTRUCTION ((X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED	
		155505		B. WING		09/02/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
					OBIN RUN W		
ROBIN F	RUN HEALTH CENT	ER		I INDIAN	APOLIS, IN46268		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	F	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	was usually doci	umented on the M.A.R.			bruit and thrill daily. All reside		
	(Medication Adr	ninistration Record) or in			receiving antibiotic therapy w	ill be	
	the nurses' notes	· · · · · · · · · · · · · · · · · · ·			oberved for continued signs		
	l the nurses notes	•			and/or symptoms of the infec		
		125 1 5 1 6 7 1			the antibiotic is being prescri		
		and M.A.R.'s for July			to treat.III. In order to preven		
	and August, 201	1 had no documentation			deficient practice from recurr all charts have been reviewe		
	of the A.V. fistu	la bruit/thrill assessment			other residents with dialysis	u 101	
	for Resident #9.				access sites and residents b	eina	
					treated with antibiotics. All	og	
	In an intervious	on 0/1/11 of 0:47 A M			residents with dialysis acces	s	
		on 9/1/11 at 9:47 A.M.,			sites will have his/her access		
	R.N. #1 indicated licensed nursing staff				assessed for bruit and thrill d	laily.	
	were supposed to	o check the A.V. fistula			All residents receiving antibion	otic	
	for bruit and thri	ll after a resident's return			therapy will be observed for		
	from dialysis.				continued signs and/or symp		
					of the infection that the antib	iotic	
	In an intervious	on 0/1/11 of 12:15 D.M			is being prescribed to treat.		
		on 9/1/11 at 12:15 P.M.,			Resident #23 was monitored		
		ated the facility's			signs and symptoms of a uri		
	pharmacy used t	o print the fistula			tract infection and completed course of antibiotic treatmen		
	assessment infor	mation on the physician			Resident #9's treatment	ι.	
	order rewrites, b	ut it was not there any			administration record was		
		ated she had asked the			updated to include daily		
		it back on the physician			monitoring of bruit/thrill. Lice	nsed	
	1	it back on the physician			nursing staff have been		
	rewrites.				re-educated on assessing dia	alysis	
					access sites and on	-	
	On 9/2/11 at 9:3	0 A.M., the D.O.N.			monitoring/documentation fo	r	
	provided a polic	y titled "Dialysis Care,"			those residents receiving		
	1 ^ .	and revised 4/01/11. The			antibiotic therapy.IV. The fac		
		but was not limited to,			will monitor the corrective ac		
		out was not minited to,			by nurse management review		
	the following:				all orders in the morning faci		
					meeting. Those residents wi orders for antibiotic therapy a		
	" 1.(b)(ii) The	access site must be			those residents with dialysis	ai iu	
	checked daily w	ith a stethoscope (bruit)			access sites will be tracked of	na I	
	1	over the site with the			monitoring form and pertinen		
	1	Document this check			documentation will be review		
	i migorups (uiiii)	. Document and check	1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED			
		IDENTIFICATION NUMBER:	A. BUI	LDING	00			
155505			B. WIN			09/02/2	U11	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
DODIN F	NIALLIE AL TIL OFAIT	- D		1	OBIN RUN W			
KORIN F	RUN HEALTH CENT	EK		INDIAN	APOLIS, IN46268			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG		day	DATE	
		Administration Record			by nursing management five a week. Licensed nurses	day		
	l ` ′	it or thrill is absent,			identified as failing to proper	ly		
	contact the attend	ding physician"			document will receive addition	onal		
					training and/or corrective act	tion		
		ecord for Resident #23			as appropriate. Nursing management will continue to	,		
		8/31/11 at 9:30 A.M.			monitor for six months and the			
	"	led, but were not limited			continue as determined by the			
	l '	betes mellitus, history of			Quality Assurance Committe			
	· ·	ction, and bipolar			and will make revisions if ne			
		sident was hospitalized			and as directed by the comn			
	from 7/1/11 to 7/	4/11 for altered mental			The Director of Nursing will ensure ongoing monitoring after			
	status due to a ur	inary tract infection.			the focused monitoring is			
					completed. V. The deficient			
	A physician's pro	gress note, dated 7/26/11			practice will be completed by	У		
	and completed by	y the Nurse Practitioner,			10/2/11.			
	indicated "Burnii	ng sensation in bladder						
	area since this A.	M." The Nurse						
	Practitioner preso	cribed Pyridium for						
	dysuria (burning	during urination) three						
	times a day for 2	days, and a U.A.						
	[urinalysis] test v	vas ordered.						
	A "Daily Skilled	Nurse's Note" entry,						
	1	5:00 A.M., indicated						
	"resident request	ed to use the bedpan						
		Had a large B.M. [bowel						
		dpan along with urine.						
	Was unable to us	-						
	specimen needed							
	_	osequent progress note at						
	_	ated "Resident was found						
	l '	responsive" The						
		ntacted and ordered vital						
	1 ^ *	fored. At 4:00 P.M., the						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 09/02/	LETED	
NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER			6370 F	ADDRESS, CITY, STATE, ZIP CO ROBIN RUN W NAPOLIS, IN46268	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	physician was contacted again "related to unstable vital signs" and ordered the resident to be transferred to an acute care hospital for evaluation.					
	dated 7/29/11 at "Resident returner night at 10:00 P. diagnosis of U.T [medication] ord voiced any compin good spirits indicated "Resid antibiotic therap	Nurse's Note" entry, 5:00 A.M., indicated ed from the hospital last M., 7/28/11 with a new T.I. Has a new med er as well. Has not plaints and appears to be " A note at 8:30 P.M., ent continues on y for U.T.I. No adverse biotic medication] noted				
	Nurse's notes entries from 7/30/11 to 8/4/11, indicated " no adverse reaction to antibiotic therapy," but did not address information related to signs and symptoms of a U.T.I. for which she was being treated.					
In an interview during the daily conference on 8/31/11 at 3:10 P.M., the D.O.N. indicated the nurses would document any continued symptoms, but did not document anything if the symptoms were lessening or absent. 3.1-37(a)						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
1:		155505	A. BUILDING B. WING		09/02/2011
NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER			STREET. 6370 R	ADDRESS, CITY, STATE, ZIP CODE COBIN RUN W JAPOLIS, IN46268	l.
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	DROVIDED'S DLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0371 SS=F	considered satisfa local authorities; a (2) Store, prepare, under sanitary cor Based on observation facility failed to the equipment adpreparation area. main kitchens an affect 70 of 70 reference in the initial on 8/29/11 at 10: Consultant Dietit following was obtained to the steamer and com greasy, gray fuzzon the area where the the residents, on	distribute and serve food diditions ation and interview, the ensure the cleanliness of diacent to a food. This impacted 1 of 1 d had the potential to esidents. I tour of the main kitchen 00 A.M., with the tian in attendance, the eserved: convection oven, the bo oven was covered in	F0371	The following is the Plan of Correction for Robin Run Healthcare Center regarding Statement of Deficiencies da 9/2/11. This Plan of Correctinot to be construed as an admission of or agreement with finings and conclusions i Statement of Deficiencies, or related sanction or fine. Rat is submitted as confirmation our ongoing efforts to comply statutory and regulatory requirements. In this docum we have outlined specific actin response to identified issue We have not provided a detaresponse to each allegation finding, nor have we identified mitigating factors. We rema committed to the delivery of quality health care services a will continue to make change and improvement to satisfy to objective. I. All residents have potential to be affected by the deficient practice. The deficient practice. The deficient contains the fitchen staff All residents residing at the fitchen staff All residents resi	with n the r any her, it of y with ent, tions es. ailed or ed in and es hat re the e ient

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/27/2011 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
155505		B. WING		09/02/2011	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
DODIN D			I	ROBIN RUN W	
ROBIN R	RUN HEALTH CENT	ER	INDIA	NAPOLIS, IN46268	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	 	DATE
	l '	Itant Dietitian indicated		have the potential to be affect by the deficient practice. The	• • • • • • • • • • • • • • • • • • •
		the convection oven,		facility will re-educate the kite	•
		bo oven needed to be		staff regarding the daily round	•
	cleaned.			cleaning schedule for the pro	pper
				cleaning techniques of the	.
	3.1-21(i)(2)			convection oven, the steame the combo oven. The	er and
				re-education will include the	daily
				routine cleaning schedule of	
				convection oven, steamer ar	nd
				combo oven, already in place	•
				In order to prevent the deficie	
				practice from recurring, the facilities will re-educate all kitchen sta	- I
				sanitary conditions in the	
				kitchen.IV. The facility will	
				monitor the corrective action	
				daily, with monitoring to be	
				completed by the Director of	
				Dining Services and/or designee dailly for one mont	h and
				daily thereafter for three mor	•
				The results will be reviewed	•
				facility's Quality Assurance	
				Committee and revisions will	
				made if needed and as direc	
				by the committee. The Direct	
				of Dining Services will ensure ongoing monitoring after the	e lile
				focused monitoring is	
				complete.V. The deficient	
				practice will be completed by	<i>'</i>
F0.465	The feetile	monda a anta firmatica al		10/2/11.	
F0465		rovide a safe, functional, fortable environment for			
SS=D	residents, staff and				
	1	ation and interview, the	F0465	The following is the Plan of	10/02/2011
		ensure the cleanliness of		Correction for Robin Run	
	1 *	akery area of the kitchen.		Healthcare Center regarding	
		of 1 main kitchens and		Statement of Deficiencies da	•
	Tins impacted I	or r main kiwhelis and		9/2/11. This Plan of Correcti	OH IS

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

B3HQ11 Facility ID:

001156

Page 9 of 13 If continuation sheet

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE	
B. WING STREET ADDRESS, CITY, STATE, ZIP CODE	
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER	
6370 ROBIN RUN W	
ROBIN RUN HEALTH CENTER INDIANAPOLIS, IN46268	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	MPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE
the potential to effect 70 of 70 residents. not to be construed as an	
admission of or agreement with	
Findings include: the finings and conclusions in the Statement of Deficiencies, or any	
related sanction or fine. Rather, it	
During the initial tour of the main kitchen is submitted as confirmation of	
on 8/29/11 at 10:00 A.M., with the	
I I gtatutory and regulatory	
Consultant Dietitian in attendance, the requirements. In this document,	
following was observed: we have outlined specific actions	
in response to identified issues. The floor of the Bakery area was found to We have not provided a detailed	
response to each allegation or	
have debris, dust and two dead bugs under finding, nor have we identified	
the shelving unit used to store items used mitigating factors. We remain	
for baking. committed to the delivery of	
quality health care services and	
During an interview on 8/29/11 at 10:10 will continue to make changes	
and improvement to satisfy that	
deficient constitution The deficient	
area needed to be cleaned. deficient practice. The deficient practice will be corrected by	
re-educating the kitchen staff.II.	
3.1-19(f) All residents residing at the facility	
have the potential to be affected	
by the deficient practice. The	
facility will re-educate the kitchen staff on routine cleaning schedule	
already in place, that covers the	
cleanliness of the floors in the	
bakery area and in the kitchen.III.	
In order to prevent the deficient	
practice from recurring, the facility	
will re-educate all kitchen staff on	
safe, functional, sanitary and comfortable conditions in the	
kitchen.IV. The facility will	
monitor the corrective action	
daily, wtih monitoring to be	
completed by the Director of	
Dining Services and/or	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/02/2011	
ROBIN F	PROVIDER OR SUPPLIER	ER	6370 R INDIAN	ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W IAPOLIS, IN46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				designee dailly for one mont daily thereafter for three mor The results will be reviewed facility's Quality Assurance Committee and revisions will made if needed and as directly the committee. The Directly of Dining Services will ensure ongoing monitoring after the focused monitoring is complete.V. The deficient practice will be completed by 10/2/11.	nths. at the I be ted ctor e the
F9999					
	to receive resider communication s following: (3) A therapy areas. This State Rule v by: Based on observe facility failed to light and the ememain dining room. This impacted 1 and the potential	NMENT AND NDARDS tation must be equipped nt calls through a	F9999	The following is the Plan of Correction for Robin Run Healthcare Center regarding Statement of Deficiencies day 9/2/11. This Plan of Correctinot to be construed as an admission of or agreement with the finings and conclusions in Statement of Deficiencies, or related sanction or fine. Rat is submitted as confirmation our ongoing efforts to comply statutory and regulatory requirements. In this docum we have outlined specific actin response to identified issue We have not provided a detay response to each allegation finding, nor have we identified mitigating factors. We remay committed to the delivery of quality health care services a will continue to make change and improvement to satisfy the objective. I. All residents have potential to be affected by the deficient practice. The deficient	with on the r any her, it of y with ent, tions es. ailed or ed in and es hat re the e

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED	
		155505	B. WING			09/02/2011	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8					
ROBIN RUN HEALTH CENTER			6370 ROBIN RUN W INDIANAPOLIS, IN46268				
					,		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION OF CORRECTI			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		+	TAG	DAIL		
	in the population of 70. Findings include:				practice was corrected on 9/1/11 by a contracted vendor repairing the dining room call light to		
				working condition. The			
					emergency intercom system	was	
	During the envir	onmental tour on 8/30/11		removed from the dining room.II.			
	at 9:55 A.M., with the Director of				All residents residing at the facility		
					have the potential to be affected		
	Housekeeping, Maintenance Engineer #1				by the deficient practice. The		
	and Maintenance Engineer #2 in				facility dining room emergency		
	attendance, the f	ollowing was observed:			call light was repaired to sou and light up in the corridor ar		
					the nurses station.III. In orde		
	When the call light in the Main Dining				prevent the deficient practice		
	Room was tested, the light did not sound				from recurring, the Director of		
	or light-up. The intercom located next to				Environmental Services and/or		
	the emergency call light box also did not				designee will ensure proper		
	work. The communication console at the				functioning of the dining room		
				emergency call light.IV. The			
	Health Care Nursing station had no area labeled for the Main Dining area call light, and there was no corresponding light lit-up for the Main Dining Room.				facility will monitor the correct action with the Director of Dire		
					of Enviornmental Services ar		
				designee monitioring dail			
					one month and weekly there		
					for three months the proper		
	During an interv	iew on 8/30/11 at 10:00			functioning of the dining roon		
	A.M., Maintenar	nce Engineer #2 indicated			emergency call light. The re		
	an emergency call from the Main Dining Room should signal by a light on the console at the Health Care Nursing station.				will be reviewed at the facility		
					Quality Assurance Committe and revisions will be made if	e	
					needed and as directed by the	ne	
					committee. The Director of	.	
					Environmental Services will		
	Daniera	: 9/20/11 10:10			ensure the ongoing monitorir		
	During an interview on 8/30/11 at 10:10				after the focused monitoring	is	
	A.M., Maintenance Engineer #indicated				complete.V. The deficient		
	the emergency intercom in the Main				practice will be completed by 10/2/11.	'	
	Dining Room was also not working.				10/2/11.		
	3.1-19(u)(3)						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	l i	E SURVEY PLETED /2011			
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
ROBIN R	UN HEALTH CENT	ER	6370 ROBIN RUN W INDIANAPOLIS, IN46268					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	ECTION	(X5)		
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	N SHOULD BE HE APPROPRIATE COMPLETION			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE		